



PERSONAL PLANNING FOR EMERGENCIES

Aging and Disability Services

240-777-3000

ADS@MontgomeryCountyMD.gov

Fire & Rescue Safety Education

240-777-2430



Use pencil to fill out one card for each person.

Fold card; insert in red magnetic pouch.

Place on refrigerator door. Update as changes occur.

Call with questions or for a new clean card.

Name: _____

Address: _____

Doctor: _____

Phone: _____

Language Spoken: _____

Blood Type: _____ Sex: ☐ M ☐ F

Date of Birth: _____ Religion: _____

Check All Medical Conditions That Exist

- | | |
|--|---|
| <input type="checkbox"/> No known medical conditions | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hard of Hearing |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Heart Valve Prosthesis |
| <input type="checkbox"/> Alcohol Addiction | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Internal Defibrillator |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irregular Heart Rhythm |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Laryngectomy |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Blind | <input type="checkbox"/> Lung Disease/Emphysema |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lymphomas |
| <input type="checkbox"/> Cardiac Dysrhythmia | <input type="checkbox"/> Malignant Hypothermia |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Memory Impaired |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Previous Heart Attack |
| <input type="checkbox"/> Dementia | Date: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Diabetes/Non-Insulin | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Other: _____ | |

ALLERGIES

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> No Known Allergies | <input type="checkbox"/> Environmental | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Horse Serum | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> X-Ray Dyes |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Novocaine | | |
| <input type="checkbox"/> Other: _____ | | |

MEDICATIONS

Medical Problem	Medication	Dosage	Frequency

Date of last flu shot: _____

Date of last pneumonia shot: _____

EMERGENCY CONTACTS

NAME: _____

Address: _____

Relationship: _____ Phone: _____

NAME: _____

Address: _____

Relationship: _____ Phone: _____

HEALTH INSURANCE INFORMATION

Health Insurance Co. Name: _____

Policy Number: _____

Other Insurance Co. Name: _____

Policy Number: _____

Medicare Number: _____

Medicaid Number: _____

HEALTHCARE DECISIONS

Do Not Resuscitate Order on file? ☐ YES ☐ NO

IF YES, Location: _____

Advance Directive on file? ☐ YES ☐ NO

IF YES, Location: _____

To access File of Life, go to
www.MontgomeryCountyMD.gov
and search for "File of Life."